Programs (Guidelines/Limitations)

Office and Other Outpatient Services [Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

The Department of Social and Health Services (the Department) covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately.

  Example: The Department does not pay separately for ventilation management (CPT®) codes 94002-94004, 94660, and 94662) when billed in addition to an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility. Nursing facility discharges (CPT code 99315 and 99316) are not included in the two-visit limitation. The Department pays for one nursing facility discharge per client, per day.

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Office and Other Outpatient Services (cont.)

- One physical examination per client, per 12 months for clients with developmental disabilities as identified in ProviderOne. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an examination.

- The Department pays one new patient visit, per client, per provider or group practice in a three-year period.

- Preventative screening services for certain conditions are covered in other sections of these billing instructions.

Children's Primary Health Care **(CPT codes 99201-99215)**

- The Department pays a higher payment rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that are paid at the higher rate.

- If a child who is younger than 60 days of age and **has not been issued** an individual ProviderOne Client ID, use the mother's ProviderOne Client ID, and put "SCI=B" in the claim notes field. Put the child's name, gender, and birthdate in the client information fields. You must also add modifier HA in order for the service to be paid at the higher rate. If the mother is enrolled in a Department managed care plan, newborns will be enrolled in the same managed care plan as their mother.

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After Hours

Afterhours office codes are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. An afterhours procedure billed for a client treated in a 24-hour facility (e.g., emergency room) is payable only in situations where a provider who is not already on-call is called to the facility to treat a client. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are scheduled to be on call at the time of service. The client's file must document the medical necessity and urgency of the service. Only one code for after hours services will be paid per patient, per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day.

For example: If a clinic closes at 5pm and takes a break for dinner and then opens back up from 6pm-10pm, these services are not eligible for afterhours service codes.

Note: This policy does not include radiologists, pathologists, emergency room physicians, or anesthesiologists. The Department does not pay these providers for afterhours service codes.

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239) [Refer to WAC 388-531-0750]

Inpatient admissions must meet intensity of service/severity of illness criteria for an acute inpatient level of care. Admission status changes must be noted in the client's chart.

What is admission status?

Admission status is a client's level of care at the time of admission. Some examples of typical types of admission status are: inpatient, outpatient observation, medical observation, outpatient surgery or short-stay surgery, or outpatient (e.g., emergency room).

Admission status is determined by the admitting physician or practitioner. Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status; consider overall severity of illness and intensity of service in determining admission status rather than any single or specific intervention. Specialty inpatient areas (including ICU or CCU) can be used to provide observation services. Level of care, not physical location of the bed, dictates admission status.

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When is a change in admission status required?

A change in admission status is required when a client's symptoms/condition and/or treatment does not meet medical necessity criteria for the level of care the client is initially admitted to. The documentation in the client's medical record must support the admission status and the services billed. The Department does not pay for:

- Services that do not meet the medical necessity of the admission status ordered;
- Services that are not documented in the hospital medical record; and
- Services greater than what is ordered by the physician or practitioner responsible for the client's hospital care.

Inpatient to Outpatient Observation Admission Status Change

The attending physician or practitioner may make an admission status change from inpatient to outpatient observation when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an inpatient client's symptoms/condition and treatment do not meet medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care;
- The admission status change is made prior to, or on the next business day following, discharge; and
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:
  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

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Outpatient Observation to Inpatient Admission Status Change

The attending physician or practitioner may make an admission status change from outpatient observation to inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an outpatient observation client's symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Inpatient or Outpatient Observation to Outpatient Admission Status Change

The attending physician or practitioner may make an admission status change from inpatient or outpatient observation to outpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an outpatient observation or inpatient client's symptoms/condition and treatment **do not** meet medical necessity criteria for observation or acute inpatient level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

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Outpatient Surgery/Procedure to Outpatient Observation or Inpatient Admission Status Change

The attending physician or practitioner may make an admission status change from outpatient surgery/procedure to outpatient observation or inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that the client's symptoms/condition and/or treatment require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Note: During post-payment retrospective utilization review, the Department may determine the admission status ordered is not supported by documentation in the medical record. The Department may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

The Department covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. The Department does not pay separately for the hospital call if it is included in the global surgery payment. (See the Surgical Services Section for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the global surgery follow-up period only if they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

Note: The Department pays providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

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The Department does not cover:

- A hospital admission (CPT codes 99221-99223) and a planned surgery billed in combination. The hospital admission is included in the global fee for the surgery.

- Inpatient or observation care services [including admission and discharge services (CPT codes 99234-99236)] for stays of less than 8 hours on the same calendar date.

Other Guidelines:

- When a hospital admission (CPT codes 99221-99223) and an emergency surgery is billed in combination, the Department will pay when there is a decision to do surgery, the provider has not seen the client for this condition, and modifier 57 is used. This only applies to surgical procedures with a 90-day global period.

- When a client is admitted for observation care for less than 8 hours and is discharged on the same calendar date, providers must bill using CPT codes 99218-99220. The Department does not pay providers separately for discharge services.

- When a client is admitted for observation care and is discharged on a different calendar date, providers must bill using CPT codes 99218-99220 **and** observation discharge CPT code 99217.

- When a client qualifies for an inpatient hospital admission and is discharged on a different calendar date, providers must bill using CPT codes 99221-99233 **and** hospital discharge day management CPT code 99238 or 99239.

- When a client qualifies for an inpatient hospital admission and is discharged on the same calendar date, providers must bill using CPT codes 99234-99236. The Department does not pay providers separately for hospital discharge day management services.

- Providers must satisfy the documentation requirements for both admission to and discharge from, inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for observation care or treatment status must also be documented.

- When clients are fee-for-service (FFS) when admitted to a hospital and then enroll in a Department managed care organization during the hospital stay, the entire stay for physician services is paid FFS until the client is discharged. Enter the following on the claim:

  - ✓ The admission date to the hospital; and
  - ✓ "Continuous hospital care" (in the *claim notes* field).

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Utilization Review

Utilization Review (UR) is a concurrent, prospective, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client's documented medical care to assure that the healthcare services provided are proper and necessary and are of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency, or quantity of healthcare services provided in relation to the condition(s) being treated. The Department uses InterQual ISDR Level of Care criteria as a guideline in the utilization review process.

- Concurrent UR is performed during a client's course of care.
- Prospective UR is performed prior to the provision of healthcare services.
- Retrospective UR is performed following the provision of healthcare services and includes both post-payment and pre-payment review.
- Post-payment retro UR is performed after healthcare services are provided and paid.
- Pre-payment retro UR is performed after healthcare services are provided but prior to payment.

Detoxification Services

The Department covers detoxification services for clients receiving alcohol and/or drug detoxification services in a Department-enrolled hospital-based detoxification center or in an acute care hospital when the following conditions are met:

- The stay meets the intensity of service and severity of illness standards necessary to qualify for an inpatient hospital stay;
- The care is provided in a medical unit;
- The client is not participating in the Department's Chemical-Using Pregnant (CUP) Women program;
- Inpatient psychiatric care is not medically necessary and an approval from the Regional Support Network (RSN) is not appropriate; and
- Nonhospital-based detoxification is not medically appropriate.

Note: Physicians must indicate the hospital's NPI in field 32 on the CMS-1500 Claim Form or in the *Comments* field when billed electronically. If the hospital's NPI is not indicated on the claim, the claim will be denied.

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When the conditions on the previous page are met, providers must bill as follows:

Procedure Code	Modifier	Brief Description	Limitations
H0009		Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.00-305.03, 305.20-305.93, and 790.3
H0009	TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

Note: Managed Care Clients who are receiving detoxification services in a detox hospital that has a detoxification-specific taxonomy can be billed directly to the Department.

Smoking Cessation

Smoking Cessation, which can include free counseling and prescription drugs, represents a major advancement in public health for Washington State. Below is a brief overview of the way the benefit works and the services available for clients in the Department fee-for-service program. For clients enrolled in managed care, contact the client's health plan for information regarding the smoking cessation benefit.

What services are available?

Refer clients to the toll-free Washington State Tobacco Quit Line for one or more of the following free services:

- Telephone counseling and follow-up support calls through the quit line;
- Nicotine patches or gum through the quit line, if appropriate; and
- Prescription medications recommended by the quit line. The client will then be referred back to their provider for a prescription, if appropriate.

The Washington State Tobacco Quit Line is:

1-800-QUIT-NOW (1-800-784-8669)	English
1-877-2NO-FUME (1-877-266-3863)	Spanish

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Who is eligible to receive these services?

- All medical assistance clients 18 years of age and older and all pregnant women regardless of age are eligible for smoking cessation services through the Tobacco Quit Line.

- Clients eligible for the Alien Emergency Medical (AEM) program or enrolled in the Family Planning Only or TAKE CHARGE programs are eligible for some of the above mentioned services; however, these clients **are not eligible** for prescription drugs and smoking cessation services provided by their primary care provider.

When a client is receiving counseling from the Tobacco Quit Line, the Tobacco Quit Line may recommend a smoking cessation prescription, if appropriate. The client will return to the provider's office with a form for you to review. Complete the form and fax it with a prescription to the Department (see the *Important Contacts* section).

When will the Department pay for a smoking cessation referral?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) when:

- The client is pregnant or 18 years of age and older;

- The client presents a Services Card and is covered by a Benefit Services Package.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program;

- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04;

- The client is evaluated, in person, for the sole purpose of counseling the client to encourage them to call and enroll in this smoking cessation program; **and**

- The referral is not billed in combination with an evaluation and management office visit.

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When will the Department pay for a smoking cessation referral for an evaluation for a smoking cessation prescription?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) for an evaluation for a smoking cessation prescription when:

- The client is pregnant or 18 years of age or older;
- The client is enrolled in this smoking cessation program;
- The client presents a Services Card and is covered by a Benefit Services Package.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program;
- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04;
- Evaluate the client for a smoking cessation prescription, with or without the client present, complete the form, and fax it to the Department Pharmacy Authorization Section, Drug Use and Review; **and**
- The referral is not billed in combination with an evaluation and management office visit.

Additional information:

- For more information about the smoking cessation benefit, call the Department at 1-800-562-3022.
- For more information about the Tobacco Quit Line, visit www.Quitline.com.
- To order brochures and business cards, go to http://www.tobaccoprc.org/TCRC.

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Emergency Physician-Related Services (CPT codes 99281-99285)

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill the Department using CPT codes 99281-99285.

> **Note**: For multiple emergency room (ER) visits on the same day with related diagnoses, the time(s) of the additional visit(s) must be noted in the *Comments* section of the claim form.

- The Department does not pay emergency room physicians for hospital admissions (e.g., CPT codes 99221-99223) or after-hours services (e.g., CPT codes 99050 and 99053).

- Physicians who perform emergency room services **must not** bill modifier 54 when billing the Department for surgical procedures.

- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

- The Department follows Medicare's policy to not pay emergency room providers for the following procedure codes: CPT codes 96360-96361 or 96365-96368.

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End-Stage Renal Disease (ESRD)

Inpatient Visits for Hemodialysis or Outpatient Non-ESRD Dialysis Services
(CPT codes 90935 and 90937)

Procedure Codes Billed	Instructions
90935 and 90937	Bill these codes for the hemodialysis procedure with all E&M services related to the client's renal disease on the day of the hemodialysis procedure. Bill these codes for the following clients: • Clients in an inpatient setting with ESRD; or • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90935	Bill using procedure code 90935 if only one evaluation is required related to the hemodialysis procedure.
90937	Bill using procedure code 90937 if a re-evaluation(s) is required during a hemodialysis procedure on the same day.

Inpatient Visits for Dialysis Procedures Other Than Hemodialysis (e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)
(CPT codes 90945, 90947)

Procedure Codes Billed	Instructions
90945 and 90947	Bill these codes for E&M services related to the client's renal disease on the day of the procedure that includes peritoneal dialysis, hemofiltration, or continuous renal replacement. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90945	Bill using procedure code 90945 if only one evaluation is required related to the procedure.
90947	Bill using procedure code 90947 if a re-evaluation(s) is required during a procedure on the same day.

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If a separately identifiable service is performed on the same day as a dialysis service, you may bill any of the following E&M procedures codes with modifier 25:

- 99201-99205 Office or Other Outpatient Visit: New Patient;
- 99211-99215 Office or Other Outpatient Visit: Established Patient;
- 99221-99223 Initial Hospital Care: New or Established Patient;
- 99238-99239 Hospital Discharge Day Management Services;
- 99241-99245 Office or Other Outpatient Consultations: New or Established Patient; and
- 99291-99292 Critical Care Services.

Critical Care (CPT codes 99291-99292) [Refer to WAC 388-531-0450]

Note: For neonatal or pediatric critical care services, see page B.19.

What is critical care?

Critical care is the direct delivery and constant attention by a provider(s) for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s); to treat single or multiple vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E&M codes.

Billing for Critical Care

When billing for critical care, providers must bill using CPT codes 99291-99292:

- For the provider's attendance during the transport of critically ill or critically injured clients 25 months of age or older to or from a facility or hospital.

- To report critical care services provided in an outpatient setting (e.g., Emergency department or office), for neonates and pediatric clients up through 24 months.

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- To report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the client and cannot provide services to any other patient during the same period of time.

> **Note:** Surgery, stand-by, or lengthy consultation on a **stable** client does not qualify as critical care.

Where is critical care performed?

Critical care is usually performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

The Department covers:

- A maximum of three hours of critical care per client, per day.
- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.
- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (36000, 36410, 36415, 36591, and 36600);
- Gastric intubation (43752 and 43753);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94002-94004, 94660, and 94662);

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- Pulse oximetry (94760 and 94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

> **Note:** Procedure code 43752 may be billed separately when it is the only procedure code billed.

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

The Department covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

> **Note:** The standby physician cannot provide care or services to other clients during the standby period.

Limitations

- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

The Department does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to Section F);
- Billed in addition to any other procedure code, with the exception of CPT codes 99460 and 99465; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99468) on the same day.

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Prolonged Services (CPT codes 99354-99357) [Refer to WAC 388-531-1350]

The Department covers prolonged services:

- Up to three hours per client, per diagnosis, per day.

Note: The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the provider and the client, whether or not the services were continuous.

- Only when the provider performs one of the services listed below for the client on the same day:

Prolonged CPT Code	Other CPT Code(s)
99354	99201-99215, 99241-99245, 99304-99350
99355	99354 and one of the E&M codes required for 99354
99356	99221-99233, 99251-99255,
99357	99356 and one of the E&M codes required for 99356

Note: Both the prolonged services CPT code ***and*** any of the "Other CPT Codes" listed above **must** be billed on the **same** claim.

Osteopathic Manipulative Therapy (CPT codes 98925-98929)
[Refer to WAC 388-531-1050]

The Department covers:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.
- OMT services by body regions. Body regions are defined as:

✓ abdomen and viscera	✓ pelvic
✓ cervical	✓ rib cage
✓ head	✓ sacral
✓ lower extremities	✓ thoracic
✓ lumbar	✓ upper extremities

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- One OMT procedure code in the range 98925-98929 per client, per day. Bill using the CPT code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT code 98926.

- An E&M service (billed with modifier 25) in addition to the OMT, under one of the following circumstances:

  ✓ When a provider diagnoses the condition requiring OMT and provides the therapy during the same visit;

  ✓ When the existing condition fails to respond to OMT or significantly changes, requiring E&M services beyond those considered included in the manipulation codes; or

  ✓ When the provider treats the client for a condition unrelated to the OMT during the same encounter.

  Justification for the E&M and OMT services must be documented and retained in the client's record for review.

Note: The Department **does not cover** physical therapy services performed by osteopathic physicians unless they are also physiatrists.

Newborn Care

To assist providers in billing CPT codes with "newborn" in the description, the Department defines a newborn as 28 days old or younger.

The Department covers:

- One newborn evaluation per newborn when they are not discharged on the same day using either CPT code 99460 for hospital or birthing center or 99461 for home births.

- Subsequent hospital care (other than initial evaluation or discharge) using CPT code 99462.

- One newborn evaluation and discharge per newborn performed in the hospital or birthing center on the same day using CPT code 99463.

Note: The Department covers circumcisions (CPT codes 54150, 54160, and 54161) ***only*** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

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Neonatal Intensive Care Unit (NICU)/ Pediatric Intensive Care Unit (PICU) (CPT codes 99468-99480)

[Refer to WAC 388-531-0900]

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team's activities.

The Department covers:

- One NICU/PICU service per client, per day.
- Intensive observation, frequent interventions, and other intensive services for neonates. Use CPT code 99477 for initial hospital care, per day, when a neonate requires intensive observation, frequent interventions and other intensive services. You may report 99460 and 99477 when two distinct services are provided on the same day, but you must use modifier 25 with 99460. Bill 99460 with modifier 25 when you see a normal newborn after an uneventful delivery and then later the infant develops complications and is transferred to an intensive setting for observation, frequent interventions, and other intensive services.
- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

  Note: Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 (>2500 grams) or 99478-99480 (<2500 grams) must be used.

- Newborn resuscitation (CPT code 99465) in addition to NICU/PICU services.
- The provider's attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT code 99466 or 99467).
- Codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger.

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The following services and the subsequent intensive, noncritical services (with their corresponding CPT codes) are included in neonatal or pediatric critical care. Do not bill these separately. Providers need to follow the national CCI edits as this list is not exhaustive:

- Bladder catheterization (51701- 51702);
- Central (36555) or peripheral vessel catheterization (36000);
- Continuous positive airway pressure (CPAP) (94660);
- Endotracheal intubation (31500);
- Initiation and management of mechanical ventilation (94002-94004);
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762);
- Lumbar puncture (62270);
- Oral or nasogastric tube placement (43752);
- Other arterial catheters (36140 and 36620);
- Umbilical arterial catheterization (36660);
- Umbilical venous catheterization (36510);
- Suprapubic bladder aspiration (51100);
- Surfactant administration, intravascular fluid administration (96360, 96361, 90780, and 90781);
- Transfusion of blood components (36430 and 36440);
- Vascular punctures (36420 and 36600); or
- Vascular access procedures (36400, 36405, and 36406).

Note: Procedure code 43752 may be billed separately when it is the only procedure code billed.

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Intensive (Noncritical) Low Birth Weight Services (99478-99480)

- Bill the appropriate procedure codes only once per day, per client.
- These codes represent care that begins subsequent to the admission date.

Physician Care Plan Oversight (CPT codes 99375, 99378, and 99380)

[Refer to WAC 388-531-1150]

The Department covers:

- Physician care plan oversight services once per client, per month.
  - ✓ A plan of care must be established by the home health agency, hospice, or nursing facility.
  - ✓ The provider must perform 30 or more minutes of oversight services for the client each calendar month.

The Department does not cover:

- Physician care plan oversight services of less than 30 minutes per calendar month (CPT codes 99374, 99377, and 99379).
- Physician care plan oversight services provided by more than one provider during the global surgery payment period, unless the care plan oversight is unrelated to the surgery.

Physicians Providing Service to Hospice Clients

The Department pays for hospice care for eligible clients. To be eligible, clients must be certified by a physician as terminally ill with a life expectancy of six months or less. Contact your local hospice agency and they will evaluate the client. Hospice will cover all services required for treatment of the terminal illness. These services must be provided by or through the hospice agency.

The Department pays providers who are attending physicians and not employed by the hospice agency:

- For direct physician care services provided to a hospice client;
- When the provided services are not related to the terminal illness; and
- When the client's provider, including the hospice provider, coordinates the health care provided.

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When billing, primary physicians must put their NPI in field 33 of the CMS-1500 Claim Form. When billing, the consulting physician, other than the primary physician, must put the following on the CMS-1500 Claim Form:

- The primary physician name or clinic name and NPI the referring provider field of the HIPAA transaction (field 17 and 17a of the CMS-1500); and

- The consulting physician's performing NPI (PIN#) in the servicing provider field of the HIPAA transaction (field 24k of the CMS-1500) and group NPI (GRP#) in the pay-to provider number field of the HIPAA transaction (field 33 of the CMS-1500).

If not related to hospice care, when billing electronically, enter "Not related to hospice care" in the claim notes field of the HIPAA transaction.

Domiciliary, Rest Home, or Custodial Care Services

CPT codes 99304-99318 are ***not*** appropriate E&M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT codes 99324-99328 or 99334-99337 for E&M services provided to clients in these settings.

Home Evaluation and Management

The Department pays for Home Evaluation and Management (CPT codes 99341-99350) only when services are provided in place of service 12 (home).

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows Department clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

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The following services are ***not*** covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; or
- "Store and forward" telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

Who is eligible for telehealth?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

The Department will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in a Department managed care plan are identified as such in ProviderOne. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan pay for telehealth.

When does the Department cover telehealth?

The Department covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, "hands on" encounter for only those services specifically listed in this section.

Originating Site (Location of Client)

What is an "originating site"?

An originating site is the physical location of the eligible Department client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital;
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

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Is the originating site paid for telehealth?

Yes. The originating site is paid a facility fee per completed transmission.

How does the originating site bill the Department for the facility fee?

- *Hospital Outpatient*: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive payment for the facility fee, outpatient hospital providers must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *Hospital Inpatient*: When the originating site is an inpatient hospital, there is no payment to the originating site for the facility fee.

- *Critical Access Hospitals*: When the originating site is a critical access hospital outpatient department, payment is separate from the cost-based payment methodology. To receive payment for the facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *FQHCs and RHCs*: When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter.

- *Physicians' Offices*: When the originating site is a physician's office, bill for the facility fee using HCPCS code Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telehealth, documentation for both services must be clearly and separately identified in the client's medical record.

Distant Site (Location of Consultant)

What is a "distant site"?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible Department client through telehealth.

Who is eligible to be paid for telehealth services at a distant site?

The Department pays the following provider types for telehealth services provided within their scope of practice to eligible Department clients:

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).

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What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241–99245 and 99251-99255);
- Office or other outpatient visits (CPT 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

> **Note**: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

How does the distant site bill the Department for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to the Department for payment.

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Audiology

[Refer to WAC 388-531-0375]

The Department covers, with prior authorization, the implantation of a unilateral cochlear device for clients 20 of age and younger with the following limitations:

- The client meets one of the following:
  - ✓ Has a diagnosis of profound to severe bilateral, sensorineural hearing loss;
  - ✓ Has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age appropriate auditory milestones in the best aided condition for young children, or score of <10 or equal to 40% correct in the best aided condition on recorded open-set sentence recognition tests);
  - ✓ Has the cognitive ability to use auditory clues;
  - ✓ Is willing to undergo an extensive rehabilitation program;
  - ✓ Has an accessible cochlear lumen that is structurally suitable for cochlear implantation;
  - ✓ Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; or
  - ✓ Has no other contraindications to surgery; and
- The procedure is performed in an inpatient hospital setting or outpatient hospital setting.

The Department covers osseointegrated bone anchored hearing aids (BAHA) for clients 20 years of age and younger with prior authorization.

The Department covers replacement parts for BAHA and cochlear devices for clients 20 years of age and younger only. See the current *Speech/Audiology Billing Instructions* for more information.

The Department considers requests for removal or repair of previously implanted bone anchored hearing aids (BAHA) and cochlear devices for clients 21 years of age and older only when medically necessary. Prior authorization from the Department is required.

For audiology, the Department limits:

- Caloric vestibular testing to four units for each ear; and
- Sinusoidal vertical axis rotational testing to three units for each direction.

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Emergency Oral Health Services

[Refer to WAC 388-531-1025]

This section does not apply to clients of the division of developmental disabilities. Refer to the *Dental Services for Clients of the Division of Developmental Disabilities Who Are 21 Years of Age and Older Billing Instructions*.

Client Eligibility

Clients age 21 and older are eligible for the oral healthcare services listed in this section, subject to coverage limitations.

Payment

The Department pays for oral healthcare services provided by a dentist to clients age 21 and older when the services provided:

- Are within the scope of the eligible client's medical care program;
- Are medically necessary as defined in WAC 388-500-0005;
- Are emergent and meet the criteria of coverage for emergency oral health benefit listed in the "Emergency Oral Health Benefit" section;
- Are documented in the client's record in accordance with Chapter 388-502 WAC;
- Meet the Department's prior authorization requirements, if there are any;
- Are within prevailing standard of care accepted practice standards;
- Are consistent with a diagnosis of teeth, mouth and jaw disease or condition;
- Are reasonable in amount and duration of care, treatment, or service;
- Are billed using only the allowed procedure codes listed in these billing instructions and the Physician-Related Services/Healthcare Professionals Fee Schedule; and

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- Are documented with a comprehensive description of the client's presenting symptoms, diagnosis and services provided, in the client's record, including the following, if applicable:

  - ✓ Client's blood pressure, when appropriate;
  - ✓ A surgical narrative;
  - ✓ A copy of the post-operative instructions; and
  - ✓ A copy of all pre- and post-operative prescriptions.

Provider Requirements

- An appropriate consent form, if required, signed and dated by the client or the client's legal representative must be in the client's record.

- An anesthesiologist providing oral healthcare under this section must have a current provider's permit on file with the Department.

- A healthcare provider providing oral or parenteral conscious sedation, or general anesthesia, must meet:

  - ✓ The provider's professional organization guidelines;
  - ✓ The department of health (DOH) requirements in chapter 246-817 WAC; and
  - ✓ Any applicable DOH medical, dental, and nursing anesthesia regulations.

- Department-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery (see WAC 388-535-1070(3)) must use only the current dental terminology (CDT) codes to bill claims for services that are listed in this section.

- Oral healthcare services must be provided in a clinic setting with the exception of trauma related services.

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Emergency Oral Health Benefit

Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, are considered a physician service, are included in the emergency oral health benefit when the services are done emergently. All services are subject to prior authorization when indicated.

The Department covers medical and surgical oral health services provided by a dentist, for clients 21 years of age and older, only when:

- Provided for the emergency treatment of pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket; or

- Part of a cancer treatment regimen or part of a pretransplant protocol.

Services Performed by a Dentist

The following set of services are covered under the emergency oral health benefit when provided by a dentist to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pretransplant protocol:

- **Emergency examination (CDT: D0140)**, one per presenting problem, performed as a limited oral evaluation to:

  - ✓ Evaluate the client's symptom of pain;

  - ✓ Make a diagnosis; and

  - ✓ Develop or implement a treatment plan, including a referral to another healthcare professional, such as an oral surgeon; or

  - ✓ A second evaluation if the treatment initiated is conservative, such as prescribed antibiotics, and a subsequent visit is necessary for definitive treatment, such as tooth extraction. The treatment plan must be documented in the client's record.

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- **Diagnostic radiographs (x-rays) (CDT: D0220, D0230, D0330).**

  - ✓ Radiographs include:

    - ➢ Periapical; and
    - ➢ Panoramic films, limited to one every three years.

  - ✓ Radiographs must:

    - ➢ Be required to make the diagnosis;
    - ➢ Support medical necessity;
    - ➢ Be of diagnostic quality, dated and labeled with the client's name;
    - ➢ Be retained by the provider as part of the client's record. The retained radiograph must be the original.

  - ✓ Duplicate radiographs must be submitted with prior authorization requests or when the department requests a copy of the client's dental record.

- **Pulpal debridement (CDT: D3221).** One gross pulpal debridement per client, per tooth, within a twelve-month period.

- **Extractions and surgical extractions for symptomatic teeth (CDT: D7140, D7210, D7220, D7230, D7240, D7241, D7250)**, limited to:

  - ✓ Extraction of a nearly erupted or fully erupted tooth or exposed root;
  - ✓ Surgical removal of an erupted tooth only;
  - ✓ Surgical removal of residual tooth roots; and
  - ✓ Extraction of an impacted wisdom tooth when the tooth is not erupted.

- **Palliative (emergency) treatment (CDT: D9110)** for the treatment of dental pain, during a limited oral evaluation appointment, limited to one per client, per six-month period,.

- **Local anesthesia and regional blocks** as part of the global fee for any procedure being provided to a client.

- **Inhalation of nitrous oxide (CDT: D9230)**, once per day.

- **House or extended care facility visits (CDT: D9410)**, for emergency care as defined in this section.

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- **Emergency office visits after regularly scheduled hours (CDT: D9440).** The Department limits coverage to one emergency visit per day, per provider.

- **Therapeutic drug injections (CDT: D9610)** including drugs and/or medicaments (pharmaceuticals) only when used with general anesthesia.

- **Treatment of post-surgical complications, such as dry socket (CDT: D9930).**

The Department covers the procedure codes in the following table when performed by a dentist to treat an acute oral health emergency.

Note: Use Expedited Prior Authorization (EPA) # 870000002 or 870000003 to indicate to the Department how clients meet emergency oral health criteria.

CDT Code	PA?	Description
D0140	N	Limit oral eval problm focus
D0220	N	Intraoral - periapical first film
D0230	N	Intraoral - periapical each additional film
D0330	N	Panoramic film
D3221	N	Gross pulpal debridement
D7140	N	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	N	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	N	Removal of impacted tooth - soft tissue
D7230	N	Removal of impacted tooth - partially bony
D7240	N	Removal of impacted tooth - completely bony
D7241	Y	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	N	Surgical removal of residual tooth roots (cutting procedure)
D9110	N	Palliative (emergency) treatment of dental pain-minor procedure
D9230	N	Analgesia, anxiolysis, inhalation of nitrous oxide
D9410	N	House/extended care facility call
D9440	N	Office visit - after regularly scheduled hours
D9610	N	Therapeutic drug injection, by report
D9930	N	Treatment of complications (post - surgical) - unusual circumstances, by report

Note: All of the previous authorization requirements related to either the procedure code itself or the site of service have not changed if and when the service is covered.

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Services Performed by a Dentist Specialized in Oral Maxillofacial Surgery

The following services are covered under the emergency oral health benefit when provided by a dentist specialized in oral maxillofacial surgery. Services that are covered under the emergency oral health benefit to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pre-transplant protocol:

- May be provided by dentists specialized in oral maxillofacial surgery; and
- Are billed using only the allowed procedure codes listed in the department's published billing instructions and fee schedules.

The Department covers the procedure codes in the following table when performed by a dentist who specializes in oral maxillofacial surgery to treat an oral health emergency. Dentists who specialize in oral maxillofacial surgery may also be paid for performing the procedures list under the "Services Performed by a Dentist" section.

Procedure Code	PA?	Description
11000	N	Debride infected skin
11044	N	Debride tissue/muscle/bone
11100	N	Biopsy, skin lesion
11101	N	Biopsy, skin add-on
11440	N	Exc face-mm b9+marg 0.5 < cm
11441	N	Exc face-mm b9+marg 0.6-1 cm
11442	N	Exc face-mm b9+marg 1.1-2 cm
11443	N	Exc face-mm b9+marg 2.1-3 cm
11444	N	Exc face-mm b9+marg 3.1-4 cm
11446	N	Exc face-mm b9+marg > 4 cm
11640	N	Exc face-mm malig+marg 0.5 <
11641	N	Exc face-mm malig+marg 0.6-1
11642	N	Exc face-mm malig+marg 1.1-2
11643	N	Exc face-mm malig+marg 2.1-3
11644	N	Exc face-mm malig+marg 3.1-4
11646	N	Exc face-mm mlg+marg > 4 cm
12001	N	Repair superficial wound(s)
12002	N	Repair superficial wound(s)
12004	N	Repair superficial wound(s)
12005	N	Repair superficial wound(s)
12011	N	Repair superficial wound(s)
12013	N	Repair superficial wound(s)
12014	N	Repair superficial wound(s)
12015	N	Repair superficial wound(s)
12016	N	Repair superficial wound(s)
12031	N	Intmd wnd repair s/tr/ext

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Procedure Code	PA?	Description
12032	N	Intmd wnd repair s/tr/ext
12034	N	Intmd wnd repair s/tr/ext
12035	N	Intmd wnd repair s/tr/ext
12036	N	Intmd wnd repair s/tr/ext
12051	N	Intmd wnd repair face/mm
12052	N	Intmd wnd repair face/mm
12053	N	Intmd wnd repair face/mm
12054	N	Intmd wnd repair, face/mm
12055	N	Intmd wnd repair face/mm
13131	N	Repair of wound or lesion
13132	N	Repair of wound or lesion
13133	N	Repair wound/lesion add-on
13150	N	Repair of wound or lesion
13151	N	Repair of wound or lesion
13152	N	Repair of wound or lesion
13153	N	Repair wound/lesion add-on
14040	N	Skin tissue rearrangement
15120	N	Skn splt a-grft fac/nck/hf/g
15320	N	Apply skin allogrft f/n/hf/g
15576	N	Form skin pedicle flap
20220	N	Bone biopsy, trocar/needle
20520	N	Removal of foreign body
20605	N	Drain/inject, joint/bursa
20670	N	Removal of support implant
20680	N	Removal of support implant
20690	N	Apply bone fixation device
20692	N	Apply bone fixation device
20902	N	Removal of bone for graft
20955	N	Fibula bone graft, microvasc
20969	N	Bone/skin graft, microvasc
20970	N	Bone/skin graft, iliac crest
21010	N	Incision of jaw joint
21025	N	Excision of bone, lower jaw
21026	N	Excision of facial bone(s)
21030	N	Excise max/zygoma b9 tumor
21034	N	Excise max/zygoma mlg tumor
21040	N	Excise mandible lesion
21044	N	Removal of jaw bone lesion
21045	Y	Extensive jaw surgery
21046	N	Remove mandible cyst complex
21047	N	Excise lwr jaw cyst w/repair
21048	N	Remove maxilla cyst complex
21049	N	Excis uppr jaw cyst w/repair
21050	Y	Removal of jaw joint

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Procedure Code	PA?	Description
21060	Y	Remove jaw joint cartilage
21070	Y	Remove coronoid process
21076	Y	Prepare face/oral prosthesis
21077	Y	Prepare face/oral prosthesis
21081	Y	Prepare face/oral prosthesis
21100	N	Maxillofacial fixation
21110	N	Interdental fixation
21116	N	Injection, jaw joint x-ray
21141	Y	Reconstruct midface, lefort
21142	Y	Reconstruct midface, lefort
21143	Y	Reconstruct midface, lefort
21145	Y	Reconstruct midface, lefort
21146	Y	Reconstruct midface, lefort
21147	Y	Reconstruct midface, lefort
21150	Y	Reconstruct midface, lefort
21151	Y	Reconstruct midface, lefort
21154	Y	Reconstruct midface, lefort
21155	Y	Reconstruct midface, lefort
21159	Y	Reconstruct midface, lefort
21160	Y	Reconstruct midface, lefort
21193	Y	Reconst lwr jaw w/o graft
21194	Y	Reconst lwr jaw w/graft
21195	Y	Reconst lwr jaw w/o fixation
21196	Y	Reconst lwr jaw w/fixation
21198	Y	Reconstr lwr jaw segment
21206	Y	Reconstruct upper jaw bone
21208	Y	Augmentation of facial bones
21209	Y	Reduction of facial bones
21210	Y	Face bone graft
21215	Y	Lower jaw bone graft
21230	Y	Rib cartilage graft
21240	Y	Reconstruction of jaw joint
21242	Y	Reconstruction of jaw joint
21243	Y	Reconstruction of jaw joint
21244	Y	Reconstruction of lower jaw
21245	Y	Reconstruction of jaw
21246	Y	Reconstruction of jaw
21247	Y	Reconstruct lower jaw bone
21248	Y	Reconstruction of jaw
21249	Y	Reconstruction of jaw
21255	Y	Reconstruct lower jaw bone
21295	Y	Revision of jaw muscle/bone
21296	Y	Revision of jaw muscle/bone
21345	N	Treat nose/jaw fracture

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Procedure Code	PA?	Description
21346	N	Treat nose/jaw fracture
21347	N	Treat nose/jaw fracture
21348	N	Treat nose/jaw fracture
21355	N	Treat cheek bone fracture
21356	N	Treat cheek bone fracture
21360	N	Treat cheek bone fracture
21365	N	Treat cheek bone fracture
21366	N	Treat cheek bone fracture
21421	N	Treat mouth roof fracture
21422	N	Treat mouth roof fracture
21423	N	Treat mouth roof fracture
21431	N	Treat craniofacial fracture
21432	N	Treat craniofacial fracture
21433	N	Treat craniofacial fracture
21435	N	Treat craniofacial fracture
21436	N	Treat craniofacial fracture
21440	N	Treat dental ridge fracture
21445	N	Treat dental ridge fracture
21450	N	Treat lower jaw fracture
21451	N	Treat lower jaw fracture
21452	N	Treat lower jaw fracture
21453	N	Treat lower jaw fracture
21454	N	Treat lower jaw fracture
21461	N	Treat lower jaw fracture
21462	N	Treat lower jaw fracture
21465	N	Treat lower jaw fracture
21470	N	Treat lower jaw fracture
21480	N	Reset dislocated jaw
21485	N	Reset dislocated jaw
21490	N	Repair dislocated jaw
21495	N	Treat hyoid bone fracture
21497	N	Interdental wiring
21550	N	Biopsy of neck/chest
29800	Y	Jaw arthroscopy/surgery
29804	Y	Jaw arthroscopy/surgery
30580	N	Repair upper jaw fistula
30600	N	Repair mouth/nose fistula
31000	N	Irrigation, maxillary sinus
31030	N	Exploration, maxillary sinus
31515	N	Laryngoscopy for aspiration
31525	N	Dx laryngoscopy excl nb
31530	N	Laryngoscopy w/fb removal
40720	Y	Repair cleft lip/nasal
40800	N	Drainage of mouth lesion

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Procedure Code	PA?	Description
40801	N	Drainage of mouth lesion
40804	N	Removal, foreign body, mouth
40805	N	Removal, foreign body, mouth
40806	N	Incision of lip fold
40808	N	Biopsy of mouth lesion
40810	N	Excision of mouth lesion
40812	N	Excise/repair mouth lesion
40814	N	Excise/repair mouth lesion
40816	N	Excision of mouth lesion
40830	N	Repair mouth laceration
40831	N	Repair mouth laceration
40840	N	Reconstruction of mouth
40845	Y	Reconstruction of mouth
41000	N	Drainage of mouth lesion
41005	N	Drainage of mouth lesion
41006	N	Drainage of mouth lesion
41007	N	Drainage of mouth lesion
41008	N	Drainage of mouth lesion
41009	N	Drainage of mouth lesion
41010	N	Incision of tongue fold
41015	N	Drainage of mouth lesion
41016	N	Drainage of mouth lesion
41017	N	Drainage of mouth lesion
41018	N	Drainage of mouth lesion
41100	N	Biopsy of tongue
41105	N	Biopsy of tongue
41108	N	Biopsy of floor of mouth
41110	N	Excision of tongue lesion
41112	N	Excision of tongue lesion
41113	N	Excision of tongue lesion
41114	N	Excision of tongue lesion
41800	N	Drainage of gum lesion
41805	N	Removal foreign body, gum
41821	N	Excision of gum flap
41822	N	Excision of gum lesion
41823	N	Excision of gum lesion
41825	N	Excision of gum lesion
41826	N	Excision of gum lesion
41827	N	Excision of gum lesion
41828	N	Excision of gum lesion
41899	Y	Dental surgery procedure
42100	N	Biopsy roof of mouth
42104	N	Excision lesion, mouth roof
42106	N	Excision lesion, mouth roof

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Procedure Code	PA?	Description
42180	Y	Repair palate
42182	Y	Repair palate
42200	N	Reconstruct cleft palate
42205	N	Reconstruct cleft palate
42210	N	Reconstruct cleft palate
42215	N	Reconstruct cleft palate
42220	N	Reconstruct cleft palate
42225	N	Reconstruct cleft palate
42226	Y	Lengthening of palate
42227	Y	Lengthening of palate
42235	Y	Repair palate
42260	N	Repair nose to lip fistula
42280	N	Preparation, palate mold
42281	N	Insertion, palate prosthesis
42330	N	Removal of salivary stone
42335	N	Removal of salivary stone
42408	N	Excision of salivary cyst
42440	N	Excise submaxillary gland
42450	N	Excise sublingual gland
42500	N	Repair salivary duct
42505	N	Repair salivary duct
42600	N	Closure of salivary fistula
43200	N	Esophagus endoscopy
64600	Y	Injection treatment of nerve
64774	N	Remove skin nerve lesion
64784	N	Remove nerve lesion
64788	N	Remove skin nerve lesion
64790	N	Removal of nerve lesion
64792	N	Removal of nerve lesion
64795	N	Biopsy of nerve
99201	N	Office/outpatient visit, new*
99211	N	Office/outpatient visit, est*
99231	N	Subsequent hospital care*
99241	N	Office Consultation*
99251	N	Inpatient Consultation*

Note: All of the previous authorization requirements related to either the procedure code itself or the site of service have not changed if and when the service is covered.

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Billing for Services that Qualify for Emergency Oral Health Benefit Package

For dates of service on and after January 1, 2011, the Department requires providers to use Expedited Prior Authorization (EPA) numbers at the header level of the claim to certify to the Department that the services provided meet the qualifications of the emergency oral health benefit. Failure to bill with an EPA number will result in claim denial.

The use of EPA numbers does not override the need for site-of-service authorization. If you are providing service in other than an office setting, prior authorization is still be required.

- To bill for services that are for pain, infection, or trauma use EPA number **870000002** at the header level.

- To bill for services that are part of a cancer treatment regimen or part of a pre-transplant protocol use EPA number **870000003** at the header level

> **Note:** Failure to bill with the appropriate EPA number at the header level will result in claim denial.

Evaluation and Management Codes (formerly hospital visits and consults)

In addition to using the EPA numbers above, dentists specialized in oral surgery must use CPT codes and follow CPT rules when billing for evaluation and management of clients. The Department covers these services when a dentist specialized in oral surgery is called to the hospital or is sent a client from the hospital for an emergent condition (i.e., infection, fracture, or trauma).

When billing for these services, the following must be true:

- Services must be billed on an 837P HIPAA compliant claim form;
- Diagnosis code(s) must evidence the emergent need; and
- Services must be billed using one of the CPT procedure codes above and modifiers must be used if appropriate.

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Billing the Client for Oral Health Care Services

- A waiver is not required when the client chooses to pay for a service that Medicaid has excluded from the client's benefit package. Refer to WAC 388-502-0160, Billing a Client, for details about billing for excluded services (effective January 1, 2011).

> **Example:** A dental client comes in and wants a crown. Medicaid has excluded crowns from the dental benefit for clients 21 years of age and older, so the provider is free to bill the client. No waiver is needed.

- A waiver is required when the client chooses to not have a treatment Medicaid covers, but prefers to pay for an excluded or noncovered treatment. Refer to WAC 388-502-0160, Billing a Client, for details (effective January 1, 2011).

> **Example:** A client comes in with an infection of the gum, which qualifies for emergency oral health treatment and a procedure in the set of covered emergency services is appropriate, but the client wants a root canal (an excluded service) instead of an extraction (an included service). The provider and the client must complete a waiver before this client can be billed.

Billing for All Dental-Related Services for Clients Served by the Division of Developmental Disabilities

For dates of service on and after January 1, 2011, the Department requires provider to use EPA number **870000004** at header level to indicate to the Department that the client is a client of the Division of Developmental Disabilities. Refer to the *Dental Services for Clients of the Division of Developmental Disabilities Who Are 21 Years of Age and Older Billing Instructions*. These billing instructions will be ready to view/download in January 2011.

Prior Authorization

The Department uses the determination process described in WAC 388-501-0165 for covered oral healthcare services for clients age 21 and older for an emergent condition that requires prior authorization (PA).

The Department requires a dental provider who is requesting PA to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on the General Information for Authorization form, DSHS 13-835, which may be obtained at http://dshs.wa.gov/msa/forms/eforms.html.

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The Department may request additional information as follows:

- Additional radiographs (X rays);
- Study models;
- Photographs; and
- Any other information as determined by the Department.

The Department may require second opinions and/or consultations before authorizing any procedure.

When the Department authorizes an oral healthcare service for a client, that authorization indicates only that the specific service is medically necessary and emergent, it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible and the service is covered in the client's healthcare benefit package on the date of service.

The Department denies a request for an emergency oral healthcare service when the requested service:

- Is not covered in the client's healthcare benefit package;
- Is covered by another department program;
- Is covered by an agency or other entity outside the department; or
- Fails to meet the clinical criteria, limitations, or restrictions in this section.

Services Excluded from the Emergency Health Benefit

- Excluded services that are essential to the completion of previously authorized services are covered. (e.g., client needs nonemergent extractions in 2011 of teeth prior to delivery of dentures that were authorized in 2010).

- Excluded services that are not essential to the completion of previously authorized services are not covered.

- Extractions being done in preparation for authorized dentures will be covered by the Department. Please put "Related to Dentures" in the claim comment field to certify that dentures are approved by the Department.

Note: Excluded services are not subject to Exception to the Rule (ETR).

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Vision Care Services
(Includes Ophthalmological Services)
[Refer to WAC 388-531-1000]

Eye Examinations and Refraction Services

The Department covers, without prior authorization (PA), eye examinations and refraction and fitting services with the following limitations:

- Once every 24 months for asymptomatic clients 21 years of age or older;
- Once every 12 months for asymptomatic clients 20 years of age or younger; or
- Once every 12 months, regardless of age, for asymptomatic clients of the Division of Developmental Disabilities.

Coverage for Additional Examinations and Refraction Services

The Department covers additional examinations and refraction services outside the limitation described above when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;
- The client is on medication that affects vision; or
- The service is necessary due to lost or broken eyeglasses/contacts. In this case:
  - ✓ No type of authorization is required for clients 20 years of age or younger or for clients of the Division of Developmental Disabilities, regardless of age.
  - ✓ Providers must follow the Department's expedited prior authorization (EPA) process to receive payment for clients 21 years of age or older. See **EPA # 610** in Section H – *Authorization.* Providers must also document the following in the client's file:
    - ➢ The eyeglasses or contacts are lost or broken; and
    - ➢ The last examination was at least 18 months ago.

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Visual Field Exams

The Department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:

- The extent of the testing;
- Why the testing was reasonable and necessary for the client; and
- The medical basis for the frequency of testing.

Vision Therapy

The Department covers orthoptics and vision therapy which involves a range of treatment modalities including:

- Lenses;
- Prisms;
- Filters;
- Occlusion or patching; and
- Eye exercises/vision training/orthoptics/pleoptics, which are used for eye movement and fixation training.

The Department requires PA for eye exercises/vision training/orthoptics/pleoptics.

Ocular Prosthetics

The Department covers ocular prosthetics when provided by any of the following:

- An ophthalmologist;
- An ocularist; or
- An optometrist who specializes in prosthetics.

Please refer to the current Department/MPA *Prosthetic and Orthotic Devices Billing Instructions* for more information on coverage for ocular prosthetics.

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Eye Surgery

Cataract Surgery

The Department covers cataract surgery, without PA, when the following clinical criteria are met:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

- One or more of the following conditions:

  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis;
  - ✓ Phacoanaphylactic endopthalmitis; or
  - ✓ Increased ocular pressure in a person who is blind and is experiencing ocular pain.

Strabismus Surgery [WAC 388-531-1000]

The Department covers strabismus surgery as follows:

Clients	Policy
17 years of age or younger	The provider must clearly document the need in the client's record. The Department does not require authorization.
18 years of age or older	Covered when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization (EPA) process. The clinical criteria are: • The client has double vision; and • The surgery is not being performed for cosmetic reasons. To receive payment for clients 18 years of age or older, providers must use the Department's EPA process (refer to Section H).

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Blepharoplasty or Blepharoptosis Surgery

The Department covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the Department's EPA process. The clinical criteria are:

- The client's excess upper eyelid skin is blocking the superior visual field; and
- The blocked vision is within 10 degrees of central fixation using a central visual field test.

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Vision Coverage Table

Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT® procedure code descriptions. To view the entire description, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92070		Fitting of contact lens	No	(Does not include any follow-up days)	On-line Fee Schedules*
Spectacle Fitting fees, monofocal					
92340		Fitting of spectacles	No		On-line Fee Schedules
92352		Special spectacles fitting	No		
Spectacle Fitting fees, bifocal					
92341		Fitting of spectacles	No		On-line Fee Schedules
Spectacle Fitting fees, multifocal					
92342		Fitting of spectacles	No		On-line Fee Schedules
92353		Special spectacles fitting	No		
Other					
92354		Special spectacles fitting	Yes		On-line Fee Schedules
92355		Special spectacles fitting	Yes		
92370		Repair & adjust spectacles	No	Applies only to clients 20 years of age and younger.	
92371		Repair & adjust spectacles	No	Applies only to clients 20 years of age and younger.	
92499		Eye service or procedure	No		

Note: Fitting fees are *not* currently covered by Medicare and may be billed directly to the Department without attaching a Medicare denial.

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: http://hrsa.dshs.wa.gov/rbrvs/index.html.

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General Ophthalmological Services					
92002		Eye exam, new patient	No		On-line Fee Schedules*
92004		Eye exam, new patient	No		
92012		Eye exam established pat	No		
92014		Eye exam & treatment	No		
Special Ophthalmological Services					
92015		Refraction	No		On-line Fee Schedules
92018		New eye exam & treatment	No		
92019		Eye exam & treatment	No		
92020		Special eye evaluation	No		
92025		Corneal topography	Yes		
92025	TC	Corneal topography	Yes		
92025	26	Corneal topography	Yes		
92060		Special eye evaluation	No		
92060	TC	Special eye evaluation	No		
92060	26	Special eye evaluation	No		
92065		Orthoptic/pleoptic training	Yes		
92065	TC	Orthoptic/pleoptic training	Yes		
92065	26	Orthoptic/pleoptic training	Yes		
92081		Visual field examination(s)	No		
92081	TC	Visual field examination(s)	No		
92081	26	Visual field examination(s)	No		
92082		Visual field examination(s)	No		
92082	TC	Visual field examination(s)	No		
92082	26	Visual field examination(s)	No		

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: http://hrsa.dshs.wa.gov/rbrvs/index.html.

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92083		Visual field examination(s)	No		
92083	TC	Visual field examination(s)	No		
92083	26	Visual field examination(s)	No		
92100		Serial tonometry exam(s)	No		
92120		Tonography & eye evaluation	No		
92130		Water provocation tonography	No		On-line Fee Schedules*
92135		Opthalmic dx imaging	No		
92135	TC	Opthalmic dx imaging	No		
92135	26	Opthalmic dx imaging	No		
92136		Ophthalmic biometry	No		
92136	TC	Ophthalmic biometry	No		
92136	26	Ophthalmic biometry	No		
92140		Glaucoma provocative tests	No		

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Ophthalmoscopy					
92225		Special eye exam, initial	No		
92226		Special eye exam, subsequent	No		
92230		Eye exam with photos	No		
92235		Eye exam with photos	No		
92235	TC	Eye exam with photos	No		
92235	26	Eye exam with photos	No		
92240		Icg angiography	No		
92240	TC	Icg angiography	No		On-line Fee Schedules*
92240	26	Icg angiography	No		
92250		Eye exam with photos	No		
92250	TC	Eye exam with photos	No		
92250	26	Eye exam with photos	No		
92260		Ophthalmoscopy/ dynamometry	No		
V2630		Anter chamber intraocul lens			
V2631		Iris support intraoclr lens			
V2632		Post chmbr intraocular lens			

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Other Specialized Services					
92265		Eye muscle evaluation	No		
92265	TC	Eye muscle evaluation	No		
92265	26	Eye muscle evaluation	No		
92270		Electro-oculography	No		
92270	TC	Electro-oculography	No		
92270	26	Electro-oculography	No		
92275		Electroretinography	No		
92275	TC	Electroretinography	No		
92275	26	Electroretinography	No		
92283		Color vision examination	No		
92283	TC	Color vision examination	No		
92283	26	Color vision examination	No		On-line Fee Schedules
92284		Dark adaptation eye exam	No		
92284	TC	Dark adaptation eye exam	No		
92284	26	Dark adaptation eye exam	No		
92285		Eye photography	No		
92285	TC	Eye photography	No		
92285	26	Eye photography	No		
92286		Internal eye photography	No		
92286	TC	Internal eye photography	No		
92286	26	Internal eye photography	No		
92287		Internal eye photography	No		

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Contact Lens Services					
92310		Contact lens fitting	No		On-line Fee Schedules*
92311		Contact lens fitting	No		
92312		Contact lens fitting	No		
92313		Contact lens fitting	No		
Ocular Prosthesis Please refer to the current Department/MPA *Prosthetic and Orthotic Devices Billing Instructions* for more information on coverage for ocular prosthetics.					
Contact Lens Services					
92314		Prescription of contact lens	No		On-line Fee Schedules
92315		Prescription of contact lens	No		
92316		Prescription of contact lens	No		
92317		Prescription of contact lens	No		

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